Medical History Questionnaire

All Information is Confidential

We would like to have this questionnaire on file in case of a medical emergency. Filling out this form could provide us with important information if you are injured.

Name of Participant: **Age:**

Gender: M F **Date of Birth:**

Guardian Name:

Phone: (Day) **(Evening)** **(Cell)**

Home Address:

Email Address:

In Case of Emergency, Contact:

Phone: (Day) **(Evening)** **(Cell)**

Physician Name: **Physician Phone:**

Yes No Do you have any allergies? List:

Yes No Do you take any medication? List:

Yes No Do you have any medical conditions?

Date of last tetanus immunization:

Is there anything else about your health we need to know in case of an emergency?

Parent Signature: _____ Date:_____

Please fill out then mail to CCCB , % Jessica Steines, PO Box 68, Grand Mound, IA 52751 by Friday, December 6th. Thank you!